

Stewart Family Chiropractic

Welcome to our practice

I am truly please that you are seeking chiropractic care and that you are considering us for your family chiropractor. I look forward to taking care of you and your family.



PATIENT INFORMATION

Date _____

First Name _____ Middle Initial _____ Last Name _____

Preferred Name (what do you like to be called?) _____ Gender M / F

Address _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Occupation _____ Employer _____

Marital Status _____ Spouse's Name _____ Number of Children _____

E-mail Address _____

Phone Numbers	Best # to call	
	Day	Early Evening
Land Line (____)____-_____	<input type="checkbox"/>	<input type="checkbox"/>
Work (____)____-_____	<input type="checkbox"/>	<input type="checkbox"/>
Cell (____)____-_____	<input type="checkbox"/>	<input type="checkbox"/>

Who may we thank for referring you to our office?

Stewart Family Chiropractic

Name _____

File Number _____

PATIENT HISTORY

* Please use back of form for long responses.

CHIROPRACTIC HISTORY

For which of these reasons did you seek chiropractic care? (Please check one)

Health Maintenance / Maximize Performance ... or

Because of a particular problem (please describe) _____

_____ Date of Onset _____

Have you had previous chiropractic care? _____ Dr.'s Name _____ Date of last adjustment _____

Did he/she take spinal x-rays? _____ Approximate date of last set of films? _____

MEDICAL/DENTAL/LIFE HISTORY

Give dates and details of any general traumas, accidents, falls, injuries, etc., that have happened over the course of your life (even if long ago)

List any surgeries (not just spinal) and broken bones that have occurred during your life _____

List any serious illnesses that have occurred during your life _____

Are you currently under medical care? _____ Dr.'s Name _____ Date of last visit _____

List current medical diagnosis and treatments _____

List medications you are currently taking (including regular use of over-the-counter drugs, such as Asprin) _____

List times you have been x-rayed, had a CAT scan, angiogram, PET scan, or MRI, and what for _____

Have you ever received radiation therapy or chemotherapy? (list) _____

List major stresses in your life _____

(Female patients) Do you have any reason to believe you may be pregnant? Yes / No

DOCTOR'S NOTES

Patient Signature _____ Today's date _____